**THE CHORLEY SURGERY**

CONSENT FORM FOR RELEASING INFORMATION TO RELATIVES

I consent to the person named below to be given information regarding my medical condition, treatment and care needs.

# PATIENT DETAILS

|  |  |
| --- | --- |
| Name |  |
| Date Of Birth |  |
| Address |  |
| Telephone Number |  |

**DETAILS OF THE PERSON YOU GIVE CONSENT TO ACCESS YOUR MEDICAL NOTES**

|  |  |
| --- | --- |
| Name |  |
| Date Of Birth |  |
| Address  |  |
| Telephone Number |  |
| Relationship to Patient  |  |

**OTHER INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are You the Patients Full-time Carer | **YES** |  | **NO** |  |
| Next of Kin Name and contact details if different from above. |  |

**PLEASE NOTE THE PATIENT WILL ALSO BE CONTACTED TO AUTHORISE THIS CONSENT FORM, PLEASE ALLOW 48 HOURS**

I consent to ………………………………………………………… being kept informed of my medical condition, treatment and care needs.

Signed: ……………………………………… Date: ………………………………..